Appendix D: Participant-Centered Planning and Service Delivery

Appendix D-1: Service Plan Development

State Participant-Centered Service Plan Title:	

a. Responsibility for Service Plan Development. Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(check each that applies)*:

☐	Registered nurse, licensed to practice in the State
☐	Licensed practical or vocational nurse, acting within the scope of practice under State law
☐	Licensed physician (M.D. or D.O)
*	Case Manager (qualifications specified in Appendix C-3)
*	Case Manager (qualifications not specified in Appendix C-3). *Specify qualifications*:
	Adult Targeted Case Managers for persons aged 16 and over in adult services: - Must possess a bachelor's degree in social work or related field from an accredited college and have one year of experience in human services, or have provided case management services, comparable in scope and responsibility to that provided by targeted case managers, to persons with developmental disabilities for at least five years; and - Have at least one year of experience in the field of developmental disabilities, or, if lacking such experience, complete at least 40 hours of training in the delivery of services to persons with developmental disabilities under a training plan reviewed by the DDP within three months of hire or designation as a case manager; and - All case managers shall participate in a minimum of 20 hours of advanced training in services to persons with developmental disabilities each year under a training plan reviewed by the DDP.
☐	Social Worker. *Specify qualifications:*
*	Other (*specify the individuals and their qualifications):*
	Family Support Specialists serving children between the ages of 0 and 21 must have a four year degree from an accredited college or university, with a major in behavioral science, early intervention, or a related field, and experience with children with disabilities. FSS certification is required within two years of date of hire, as outlined in ARM 37.34.2106. The FSS certification requirements are available from the DDP upon request.

b. Service Plan Development Safeguards. *Select one:*

*	Entities and/or individuals that have responsibility for service plan development *may not provide* other direct waiver services to the participant.
*	Entities and/or individuals that have responsibility for service plan development *may provide* other direct waiver services to the participant. The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify*:

For adult services-
Adult Targeted Case Managers *may not provide* other direct waiver services, and the agencies employing the contracted case managers may not provide other waiver services in the same community in which the client is served by the adult TCM. The DDP enables both state and contracted Adult Case Managers to authorize the plans of care as the DDP approval authority.

For children's services-
Family Supports Specialists (FSS) providing case management to children served in IFES, *may provide* other direct services to recipient and the family. In addition, the agency employing the FSS may provide other waiver reimbursed services to the child or family. The provision of IFES case management and other direct waiver services is based on a sole provider in some communities. No geographic service area has more than two child and family service providers serving the same community. The option of choice of provider is made available to the recipient and family via the Freedom of Choice form. Families can and do request the services of a new case manager within when desired. Because of the potential for conflict of interest with the case management agency providing other supports to the child and family, 100% of the IFES plans of care are reviewed by the DDP QIS as the DDP approval authority.

Other protections include-

1. Annual agency consumer satisfaction forms reviewed as part of the DDP QA process.
2. Annual consumer satisfaction surveys sent to all waiver service recipients by the provider.
3. All providers have policies outlining the corporate grievance/dispute resolution procedure. Unsatisfied recipients or families can appeal to the Department, as required by rule. The form of the appeal (e.g., Department planning meeting appeal process versus cause for fair hearing) is determined by the Department, based on the specific circumstances.

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

For adult services-
Notification of the planning meeting is sent by the case manager to the family, guardian (if applicable) and representatives of other agencies involved in providing services to the recipient and family. The IP meetings are based on provider assessments and pre-meeting consumer satisfaction surveys conducted by the case manager. In addition, consumer satisfaction surveys generated by service providers are made available to case managers and may be used by the case manager to address service delivery issues in the plan of care. The planning document must be approved by the service recipient and/or legal guardian. The client and /or legal guardian reserve the right to decide who will be attending the planning meeting, except the recipient does not have the authority

to limit attendance by his/her full legal guardian. Plan input and guidance from the recipient and interested others is actively encouraged by the case manager.

For children's services-

Notification of the planning meeting is sent by the case manager to the parents (unless contact has been limited), surrogate/foster parents, if applicable and representatives of other agencies involved in, or providing services to, the child and family. Family members and/or primary caregivers are actively involved in the selection of the assessments to be completed by the FSS, based on the needs and desires of the family and child. Meeting attendees include any persons requested or approved by the family. Written input and recommendations from persons who cannot attend is reviewed on or before the meeting. The guardian or surrogate parent has the authority to approve or deny any of the planning meeting outcomes.

d. Service Plan Development Process In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable)

For Child and Family Services:

The Family Support Specialist (FSS) schedules a meeting with persons who play a role in the lives of the recipient and family. The family or guardian determines who will be invited to the meeting by the FSS. School personnel may be invited, conversely, parents are typically involved in school IEP meetings.

Child and family (C&F) service providers review a variety of assessments depending on the identified needs of the child and family. OT, PT, speech and other therapy assessments are completed by licensed professionals who accept Medicaid reimbursement. Health and medical information is reviewed, based on dental, vision, auditory, health, nutritional and other medically related assessments and the resultant recommendations from medical professionals. School assessments may be requested and incorporated in the plan. Social/behavioral, motor, cognitive learning and self-help assessments are generally completed by an agency staff person and are often assigned to the FSS working directly with the primary care giver. In some cases, comprehensive evaluation and diagnostic (E&D) evaluations will be requested for a recipient new to IFES services. This service is available through two C&F service providers under a General Fund DDP contract, and is helpful in generating prescriptive recommendations for follow up by the child's planning team. E&D evals employ licensed (speech, OT, PT) therapists, pediatric physicians and other professionals, as needed.

The assessment tools and the Individualized Family Service Plans (IFSP) forms used by child and family service providers vary, but the content of the planning documents is similar from provider to provider. Copies of various assessments and planning documents used by C&F providers are available upon request. A sample set of C&F planning documents may be reviewed in Appendix E of the last waiver renewal, effective 7/1/03.

Effective 7/1/07, the child planning process will include a form listing all the potential waiver services available to a recipient and/or family member.

Rather, the family is asked how the C&F agency can best help them. This approach forms the basis of the assessments completed or coordinated by the case manager. The assessment results and recommendations, and the expressed desires of the family, guide the decisions made at the planning meeting, and often result in specific goals and objectives related to the needs of the child or the family. In addition to assessments, the outcome medical appointments are reviewed, and schedules are typically developed to help ensure the provision of generic and specialized health services. All goals and objectives in the planning document are subject to the approval of the family.

Many of the resource objectives coordinated by the FSS are not waiver-funded. Specifically, many of these resources are funded under the State Plan, through EPSDT, or under private health insurance, through the public education system, the OPA office or through other resource agencies potentially available to the family. Often, the family is unaware of all the resources they may be eligible to receive prior to entering IFES services. The level of training and experience necessary for the FSSs to provide a competent level of case management to the family is best understood by reviewing the FSS certification requirements, as outlined in The Certification Handbook, A Guide for Montana's Family Support Specialists. The certification process is outcome-based and helps ensure a very high quality of service in the agency delivery of Family Supports Coordination.

The IFSP forms used by C&F agencies have commonality in listing the objectives, person responsible, the start date and the expected completion date. These objectives are generally split into the categories of child focused, family focused and resource/support coordination. The parent may not consent to all the recommendations, and retains the authority to approve or reject any of the recommendations and meeting outcomes. The outcomes specifically approved by the parent/guardian/surrogate are documented signed and dated on a parent consent form. This is the basis of services to the family and child for the next year.

All families with a child in IFES meet every six months after the initial IFSP (one initial and one review meeting is held annually). Outcomes and progress on the previously assigned objectives is documented at the review meetings. Frequently, additional meetings or face-to-face visits are held in response to family request. The planning document is modified, as needed, and remains a "working document" until the next scheduled IFSP.

C&F providers have various policies governing the internal review and monitoring of the performance of the FSS serving to ensure successful child and family outcomes. Often, a sample of IFSPs and FSS case notes are reviewed by the agency person designated for this activity. In addition, a supervisor may schedule a home visit with a family to review how things are working out with the assigned FSS. Finally, annual consumer evaluations are sent to every family served by the agency and a very high percentage of these evaluation forms are returned. All of these steps help ensure a high level of customer satisfaction. The QA review process used by the DDP QIS in verifying compliance with DDP requirements is outlined in Appendix H of this document.

Requirements related to the delivery of the IFES service are detailed in code, rule and DDP and provider policies and Appendix B of the DDP contract. The relevant codes and rules may be viewed via the State of Montana home page via internet web links to legal resources. Policies are maintained by service provider agencies and the DDP policies are maintained in the DDP satellite, regional and central offices and are available upon request. Some of the codes, rules and policies governing this section include:

1. Policies and Procedures For Intensive Family Education and Support Services
2. Montana's Comprehensive Evaluation Process for Child and Family Services
3. ARM 37.34.201, 37.34.208, 37.34.266, 37.34.602, 37.34.604, 37.34.609, 37.34.609, 37.34.612, 37.34.613,37.34.616, 37.34.901 and 37.34.2106
4. MCA 53-20-201 through 53-20-205 and 53-20-209

Adult Services Plan of Care Development

The DDP is in the process of implementing a Personal Supports Planning (PSP) process, in lieu of the current Individual Planning process. Until the PSP process is finalized and adopted on a statewide basis, the current process is outlined in Individual Planning: A Training and Reference

Manual for the Individual Planning Process.

The Adult Targeted Case Manager (TCM) schedules an annual planning meeting with persons who play a role in the life of the recipient. If the recipient has a legal guardian, the guardian would be considered an essential member of the team. Meetings may be scheduled more frequently than annually, at the request of any team member, for any purpose.

In preparation for the annual meeting, the case manager will meet with the recipient (and often, a primary care giver) for the purpose of completing the Consumer Satisfaction Survey, as outlined in Appendix J of the Developmental Disabilities Program Quality Assurance Process. Service providers complete assessments based on the needs of the recipient, and the services for which the providers are contracted to provide. These include residential assessments and work/supported employment/vocational assessments.

At the meeting the status of objectives set at previous meetings is reviewed. Medical appointments and current medications are listed and reviewed, and the need for medical appointments and other assessments as outlined on the DPHHS-DDP-IP-005 is reviewed for any required follow up. Waiting list information and long range goals are reviewed and follow up objectives are assigned, if needed. Any proposed rights restrictions are reviewed and approved (or rejected) via the IP-011 form. Training and service coordination goals may be set to address residential or vocational needs, including behavior support needs. The 014 form reviews health/safety related information specific to the recipient across four broad risk areas:

1. Health considerations.
2. Safety considerations (applicable to persons living in apartments or at home).
3. Safety considerations for persons in any residential or vocational setting.
4. Financial/legal considerations

Planning meeting outcomes are based on the agreement of all participants.

The participant and family/guardian may not be fully informed of all the services potentially available under the waiver. There is no dedicated planning form that serves as a "menu" of waiver service options. This will change as the state moves from a "slot driven" system of supports to a more individualized system, wherein the recipient has more choice and authority over the use of his resource allocation. As mentioned previously, service recipients will have increased authority over their resource allocations; this is one of the significant differences between persons served in the rates methodology project in DDP Region 2, and persons currently served in the other four regions of the state.

Effective 7/1/07, the adult planning process will include a form listing all the potential waiver services available to a recipient an/or family member.

All recipients in adult services will have an annual planning meeting, and all adult service providers are required by rule (ARM 37.34.1108) to complete quarterly status reports describing progress on objectives assigned at the previous planning meeting. These reports go to the case managers, and the case manager is responsible for follow up, if necessary.

Case management offices use various strategies for internally reviewing and monitoring the performance of TCMs. Samples of individual plans of care and case notes are reviewed by the case manager supervisor. In addition, a supervisor may schedule a home visit with a family to review how things are working out with the assigned TCM. The consumer satisfaction surveys completed by case managers are reviewed by the TCM supervisors as another form of quality control. Contracted case management agencies send out a consumer feedback form to all recipients

receiving services and these are reviewed and summarized by management staff. All of these steps help ensure a high level of customer satisfaction. Finally the DDP QIS reviews a sample of the plans of care as part of the annual QA review process.

Requirements related to the delivery of the case management service are detailed in the State Plan, DDP and provider policies, codes, and rules and Appendix C of the DDP contract, if applicable. The relevant codes and rules may be viewed via the State of Montana home page via internet web links to legal resources. Policies are maintained by service provider agencies, and the DDP policies are maintained in the DDP satellite, regional and central offices and are available upon request. Some of the codes, rules and policies governing this section include:

1. Individual Planning: A Training and Reference Manual for the Individual Planning Process
2. Personal Support Plan Instructions for Form Document and Completion
3. DD Case Manager's Handbook
3. ARMs 37.86.3301 through 37.86.3306 and 37.86.3601 through 37.86.3607 relate to the provision of services under the State Plan. Other planning meeting references include 37.34.917 through 37.34.919 and 37.34.1101 through 37.34.1115.
4. MCA 53-20-201 through 53-20-205 and 53-20-209

e. Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

Child and Family Services

Assessments of risk are related to two broad areas:

1. Identification of risk factors linked to the increased potential for the abuse, neglect or exploitation of the child.
2. Identification of risk factors, which, if not addressed, could interfere with the child's emotional, cognitive, social and physical development.

Entering Child and Family Services:
The FSS or assigned agency staff person develops a referral packet for all children found eligible to receive IFES. The referral packet includes diagnostic information, evaluation results, social history information, stress factors on the family, expressed needs of the family and other related information. When there is a service opportunity, this information is reviewed and the applicant is assigned a numerical score by screening team members. Family stress and other "at risk" factors (e.g., severe behavior problems or significant deficits in self-help skills) influence the service level scores assigned to the child and family. Children with the highest service level scores are prioritized for selection at screenings. The Department Policies and Procedures for Intensive Family Education and Support Services and the Intensive Family Education and Support Services Application Packet are available upon request if more detail is desired.

Ongoing Child and Family Services are based on planning meeting assessments previously mentioned. All C&F agency staff are mandatory reporters of suspected abuse, neglect or exploitation; families are informed of this prior to the initiation of service. In addition, at least one C&F agency provides generic information to family members outlining examples of abuse and the

signs and symptoms of abuse based on the behavior of the child. A toll free number is included in the document enabling a family to call the child abuse hotline. This is considered a best practice.

Back up support to families is available via on call systems linking them to an assigned agency staff person. In general, back up plans for children are less critical when the child is receiving 24/7 support in a family home.

Adult Services

Assessments of risk are related to two broad areas:

1. Identification of risk factors linked to the increased potential for the abuse, neglect or exploitation of the adult.
2. Identification of risk factors, which, if not addressed, could interfere with the recipient's cognitive, social and physical development, or reduce the potential for independence and/or reduce life choices and options based on behavioral issues or adaptive behavior deficits.

Entering Adult services

The Adult Targeted Case Manager or assigned agency staff person develops a referral packet for a person found eligible to receive DDP waiver funded adult services. The referral packet includes diagnostic information, evaluation results, behavior and adaptive behavior assessments, social history information, expressed needs and desires of the family and recipient and other related information. This information is reviewed by screening team members prior to the screening meeting. Current level supports and other "at risk" factors (e.g., severe behavior problems or significant deficits in self-help skills) influence decisions made by the screening committee. In the case of service opportunities in a congregate setting, the needs of the referred recipient are balanced with the projected compatibility with other persons in the residential or work setting. The Case Management Handbook, and the Referral/ Waiting List Procedures Manual serve to outline the required information needed for referrals and screenings. These documents are available upon request.

Ongoing Adult Services

Risk assessment and mitigation are based on planning meeting assessments and these are individualized based on the service setting and needs of the recipient. All adult service provider staff serve as mandatory reporters of suspected abuse, neglect or exploitation. Back up support to persons in non-congregate settings is available via on call systems linking them to assigned agency staff person. In general, back up plans for persons in congregate settings are less critical and the provider systems and policies to maintain staffing ratios are individualized by service provider agency, based on the needs of recipients. Training and service objectives related to the mitigation of risk are given a very high priority during the planning process. As previously mentioned, the IP Form 014 Health, Safety, Financial Considerations Form serves to systematically review and address risk mitigation for adult service recipients.

f. Informed Choice of Providers. Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

Entering Children's Services

The following entrance process is defined in detail in Policies and Procedures for Intensive Family Education and Supports.

If a referral for IFE&S services is initially made for an individual who is not currently receiving any DDP waiver funded services, then the family's *first step* is to select a qualified Child and Family (C&F) provider (Section IV.A herein). The *second step* is for this provider to determine if the individual has a developmental disability (Section IV.B herein). If eligible, the *third step* is to determine if the individual is eligible to be placed on the waiting list for IFE&S services (Section IV**.**C herein).

A C&F provider informs the applicant of the provider options when there is more than provider available for a specific community. Generally, the provider who performs the intake activities and develops the referral is the provider of choice, but applicants retain the option of selecting another provider prior to a service vacancy and the referral would be forwarded to the provider of choice. Screenings for openings involve a screening committee made up of representatives from the available providers, and at least one QIS. All high priority referrals are reviewed. A standardized tool is used to assign a point value to referral. Screening outcomes are based on a majority vote. The person offered an IFES service opportunity has the option of choosing any available service provider before services are initiated.

Ongoing Children's Services

The Family Support Specialist presents the information listed on the Waiver 5 Freedom of Choice form to the family on annual basis. The relevant section of the form follows:

I have been fully informed that I will be given the opportunity to choose the provider of service(s) when more than one provider is available to render the service(s).

I have been advised of the State of Montana fair hearing process if I am denied the service(s) of choice or the provider(s) of choice.

After reviewing my options and choices, I freely choose to (*check all that apply*):

_____ Receive services in the community via the HCBS DD Medicaid Waiver.
_____ Receive services from my existing provider(s).
_____ Receive services from a different provider (specify). _____
_____ Not receive waiver-funded services at this time.

Comments _____

_____
Client and/or Guardian Signature Date

_____
Targeted CM or C&F Provider Rep. Signature Date

_____
Department Representative Signature Date

Entering Adult Services

The educational responsibilities of the assigned case manager in informing individuals of their service options and provider choices are outlined in the DD Case Manager's Handbook and the Referral/Waiting List Procedures Manual. This includes meeting the recipient and family, reviewing the local and statewide service providers, reviewing and/or providing brochures from local providers, arranging tours or visits with local providers, and providing contact information for potentially any of the qualified providers listed in the Directory of Services For Persons With Developmental Disabilities. The service directory is updated annually. The pertinent language from the Waiver 5 form (above) is shared upon entry into services.

Ongoing Adult Services

Recipients in adult services can choose to "port" their service allocation to another qualified provider. Persons in the DDP Regions 1,3,4 and 5 living in congregate residential settings may not port to unlike services at this time. Recipients in the Region 2 rates methodology project have the ability to choose the services and/or providers of choice with their resource allocation. The Region 2 rates methodology project will be implemented statewide in accordance with Legislative language over the next 2.5 years, as outlined in Appendix I-2:1.

It is the responsibility of the TCM to ensure that persons in adult services are aware of the service options. The Waiver 5 form, completed annually by the case manager, helps ensure that recipients and persons acting on their behalf understand their options and choices. Plan of care activities of the case manager include the completion of the Consumer Satisfaction Survey prior to the meeting. This document may be reviewed in Appendix J of the Quality Assurance Process for adult services.

The current adult planning process used statewide is currently being revised to better enable persons to choose their services and plan their futures. A field test of the process and forms is being implemented at the time of this writing. Details regarding the process and forms are available upon request in the Personal Support Plan Form and Information Gathering Documents: Field Test Version and the Instructions for PSP Forms & Process.

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

In children's services, the Individualized Family Service Plan (IFSP) is made available to the DDP QIS assigned to the C&F agency. The DDP QIS reviews 100% of the plans, and will follow up with the provider if there is a problem with the plan of care. The C&F provider will implement the plan unless a Department representative contacts the Family Support Specialist responsible for plan development. The following ARM applies:

37.34.917 MEDICAID HOME AND COMMUNITY SERVICES PROGRAM: INDIVIDUAL PLANS OF CARE (1) Individual plans of care for recipients of medicaid

home and community services must:
(a) conform with ARM 46.8.105 or alternative procedures approved by the department;
(b) include a description of each service to be provided, the frequency of those services, and the type of provider; and
(c) include the projected annualized costs of each service.
(2) The individual plan of care must be reviewed and approved by the department. (History: Sec. 53-2-201, 53-6-113, 53-6-402 and 53-20-204, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-402 and 53-20-205, MCA; NEW, 1992 MAR p. 1490, Eff. 7/17/92; TRANS, from SRS, 1998 MAR p. 3124.)

In adult services, the Individualized Plan (IP) is approved by the Adult Targeted Case Manager. These plans are made available to the DDP QIS, but the QIS does not review these plans as part of the approval process. Because the Adult TCM is either a state employee or an employee of agency providing case management only services to the recipient, DDP believes there is no conflict in designating the case manager as the Department approval authority. The DDP QIS monitors a sample of the plans for quality control purposes as part of the annual QA process.

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. *Specify the minimum schedule for the review and update of the service plan:*

○	Every three months or more frequently when necessary
○	Every six months or more frequently when necessary
*	Every twelve months or more frequently when necessary
○	Other schedule (*specify*):

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §74.53. Service plans are maintained by the following *(check each that applies)*:

*	Medicaid agency
☐	Operating agency
*	Case manager
*	Other (*specify):*
	Service providers maintain copies of the plans.

Appendix D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.Children's Services

The Family Support Specialist is responsible for developing, implementing and monitoring the Individual Family Service Plan (IFSP), and the monitoring of the participant's health and welfare, in accordance with the definition of Family Supports Coordination. Review and follow up to the plan occurs at the six month IFSP review meeting. Internal reviews of IFSP outcomes and status of ongoing objectives are completed on a sample basis by assigned staff within the child and family agency.

The DDP QIS reviews a minimum sample of five plans of care as part of the annual Quality Assurance Review, in accordance with the review requirements outlined in Montana's Comprehensive Evaluation Process for Child and Family Services. Specifically, the 12 IFSP related checklist items are reviewed under Section 1 of The Evaluation Checklist for Child & Family Services.

Adult Services

The Adult Targeted Case Manager is responsible for developing, implementing and monitoring the Individualized Plan (IP). The service provider is responsible for generating quarterly status reports. This process is defined in ARM 37.34.1108, as follows.

37.34.1108 INDIVIDUAL PLAN: STATUS REPORTS AND ANNUAL PLANNING MEETING (1) For each person receiving services, an individual plan status report must be produced on a quarterly basis.

(a) Each corporation providing services for the person receiving services must assign a representative to participate in the development of the quarterly individual plan status report.

(b) A copy of the individual plan status report must be provided to:

(i) the case manager; and

(ii) the developmental disabilities program program office, if the case manager is a contracted case manager.

(c) An individual plan status report must include the following:

(i) a summary of progress toward the attainment of the objectives listed in the individual plan;

(ii) the need for or the action taken to assure progress; and

(iii) the need, if any, to reconvene the individual planning team.

(d) The case manager will, depending on the individual plan status report:

(i) discuss the information with an assigned representative from the corporation;

(ii) observe the implementation of objectives;

(iii) review individual progress data to determine if there is a sufficient lack of progress to necessitate notification of the individual planning team; and

(iv) send individual plan status reports to other planning team members upon request.

(2) The individual planning team must meet at least annually to

formally review the goals and objectives established at the previous planning meeting. In reviewing the previous plan, the team shall:

(a) analyze progress data for each objective selected at the last team meeting;

(b) modify the goals and objectives as necessary;

(c) determine satisfaction with current services and supports; and

(d) determine further services and supports that are needed.

(History: Sec. 53-2-201 and 53-20-204, MCA; IMP, Sec. 53-20-203, MCA; NEW, 1993 MAR p. 1353, Eff. 6/25/93; AMD, 1996 MAR p. 2188, Eff. 8/9/96; TRANS, from SRS, 1998 MAR p. 3124.)

In addition, the Quality Assurance Review conducted by the QIS requires the review of a minimum of five service plans. Specifically, Appendix B: The IP Checklist reviews the following eleven critical elements related to the planning document:

_____ Individual Preference/Needs Identified Through Comprehensive Assessments/Surveys

_____ Individual Preferences/Needs Addressed in Plan of Care

_____ Satisfaction with Last Year's Plan

_____ Evidence of Individual Attendance at meeting/Reason for No Attendance

_____ Objectives Measurable

_____ Objectives Matched to Long-Range Goals

_____ Rights Restrictions (Training and QIS Approval)

_____ Medications Self-Administered

_____ Consumer Survey / Concerns Addressed

_____ Hours of Service Specified in Last Year's IP Verified as Being Delivered In This IP

_____ All Areas Covered

b. Monitoring Safeguards. *Select one:*

	Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare *may not provide* other direct waiver services to the participant.
*	Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare *may provide* other direct waiver services to the participant. The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify*:
	The contracted Adult Targeted Case Managers may not provide other direct waiver services to the recipients in adult services. Children's Services The Family Support Specialists (FSS) providing family supports coordination are employed by child and family service provider agencies, and these agencies provide (directly or via subcontracts) all the waiver-reimbursed services to children served in Intensive Family Education and Supports (IFES). As previously noted, the FSS is primarily responsible for monitoring the progress of the IFSP, and many of the IFSP objectives are assigned to the FSS. DDP has developed safeguards to ensure that plans are appropriate and effectively meet the needs of the individual. These safeguards include: 1. All plans of care (IFSPs) are reviewed by the DDP QIS. The QIS is familiar with the recipient because the QIS conducts the initial and annual Level of Care re-determinations. 2. Consumer surveys are conducted on a sample of recipients as part of the review process. High levels of customer satisfaction with services provide an additional assurance 3. The DDP QIS reviews a sample of the documentation verifying that information was shared with families regarding the availability of choice of services and choice of service providers during the QA review process for C&F services.